Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

March 20, 2018

Mr. Shawn Hallisey, Administrator
Greensboro Nursing Home
47 Maggie's Pond Road
Greensboro, VT 05841-8800

Dear Mr. Hallisey:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 14, 2018.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475043	A. BUILDING _____ B. WING _____	02/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSBORO NURSING HOME	47 MAGGIE'S POND ROAD GREENSBORO, VT 05841

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments During an unannounced onsite re-certification survey on 2/12 - 2/14/2018, the facility was found in substantial regulatory compliance regarding emergency preparedness planning activities.	E 000		
F 000	INITIAL COMMENTS An unannounced onsite re-certification survey was conducted by The Division of Licensing and Protection from 2/12 -2/14/2018. The following regulatory deficiencies were identified during the survey.	F 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.	F 623	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F623 For resident #12 and all residents of the facility the nurse management Team and medication nurse and the Social Worker have been in serviced on the requirements to provide notice of transfer. The Administrator or designee will audit weekly all transfers and discharges to assure that all residents, families, and the Ombudsman are notified. All out comes will be reviewed at QAPI. The Social Worker will be responsible for this plan of correction.	3/5/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shawn T. Hallisey	Administrator	3/5/18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 623	Continued From page 1 (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; . (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for	F 623	F623 POC accepted 3/19/18 LLovell RN/pmc	

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F 623	Continued From page 2 the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to notify 1 applicable resident in the sample of 20 residents (Resident # 12) and the resident's representative(s) of a transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a	F 623		

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F 623	Continued From page 3 representative of the Office of the State Long-Term Care Ombudsman. Findings include: 1. Per record review, Resident # 12 was transferred to an acute care hospital on 11/9/17 and returned to the facility on 11/13/17. Resident # 12 was again transferred to a hospital on 12/14/17 and returned to the facility on 12/16/17. There is no evidence in the clinical record that the resident, the resident's representative or the Ombudsman was notified in writing of the transfers to the hospital. On 2/13/18 at 12:56 PM, the Administrator the confirmed that neither the resident, resident representative or the Ombudsman was notified in writing regarding the transfers to the hospital and stated that the facility was not currently complying with this regulation.	F 623	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and	F 625	F 625 For resident #12 and all residents of the facility the Social Worker, Nurse Managers, and all RN's and LPN's have been in serviced on the Notice of bed hold policy and return. The Administrator or designee will audit weekly all transfers to ensure that the resident and responsible party are notified in writing of the pertinent information as required. All outcomes will be reviewed at QAPI. The Social Worker will be responsible for this plan of correction.	3/5/18

F625 POC accepted 3/19/18 Lowell RN/PMC

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F 625	Continued From page 4 (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to provide written information to the resident or resident representative for 1 applicable residents in the sample of 20 (Resident #12) regarding bed-holds. Findings include: 1. Per record review, Resident #12 was transferred to an acute care hospital on 11/9/17 and returned to the facility on 11/13/17. Resident # 12 was again transferred to a hospital on 12/14/17 and returned to the facility on 12/16/17. There is no evidence in the clinical record that the resident or the resident's representative was provided written notice which specifies the duration of the bed-hold policy. On 2/13/18 at 12:56 PM, the Administrator confirmed that neither the resident or resident's representative was provided written notice which specifies the duration of the bed-hold policy after transfers to the hospital.	F 625		
F 645 SS=B	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals	F 645		

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F 645	Continued From page 5 with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the	F 645	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F 645 For resident #16 and all residents of the facility Social Service/Admissions has been in serviced on the PASRR requirement. Social Worker/Admissions has set-up a system to monitor and ensure that the PASRR requirements are met for all admissions. The Administrator or designee will audit all admissions weekly to ensure that all admissions have a PASRR and the PASRR process is followed. All outcomes will be reported to QAPI. The Social Worker/Admissions is responsible for the plan of correction.. F645 POC accepted 3/19/18 LLovell RN/PMC	3/5/18

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F 645	Continued From page 6	F 645		

preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to ensure that all applicants to a Medicaid-certified nursing facility received evaluation for serious mental disorder and/or intellectual disability. Pre-Admission Screening (PASRR) was not appropriately conducted for 1 of 20 residents in the sample (Resident #16). Findings include:

During medical record review, it was found that Resident #16 had a 30 day exemption PASRR from the hospital on file, dated 11/27/17, due to an expectation of a stay of 30 days or less. When

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F 645	Continued From page 7 it was determined that Resident #16 would remain in long term care, and after the 30 days had lapsed, the facility failed to complete a Level 1 PASRR screening for the change to long term care status. During interview on 2/14/18 at 10:12 AM, the Director of Social Services confirmed that the facility did not have a system in place to screen each resident for Level 1 PASRR unless a diagnosis of mental illness or intellectual disability was known at admission [and thereby requiring review for Level 2 services].	F 645		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store, prepare, distribute and serve food in accordance with professional	F 812	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F 812 For all residents of the Facility all dietary staff have been in serviced on the proper procedure for storing, preparing, distributing, serving food, and cleanliness in accordance with professional standards. The Food Service Supervisor or designee will audit 5x weekly all areas of concern. All outcomes will be reviewed at QAPI The FSS will be responsible for this plan of correction. F812 POC accepted LLovell RN/PMC 3/19/18	3/5/18

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F 812	Continued From page 8 standards for food service safety. Findings include: During the initial tour of the kitchen accompanied by the Dietary Manager (DM) on 2/12/18 at 09:30 AM, the following was observed in the walk-in refrigerator: 1. A large plastic bag identified as cooked chicken by the DM. The bag was on the bottom shelf of a wire rack. The bag was pierced by chicken parts at the bottom in several places. The bas was not labeled as chicken nor was it dated. 2. An open plastic bag containing cooked turkey sausage as identified by the DM. The bag was unsecured and open to air at the top. The bag was not labeled as sausage nor was it dated. 3. The kitchen floor in multiple areas was heavily soiled with debris and grease. 4. There was a viscous yellowish substance on the inside of the ice machine directly over the exposed ice. 5. The microwave oven was soiled on both the inside and the outside with food particles and grease. The above was confirmed at the time of the observations by the DM. Based on staff interview and record review, the facility failed to ensure that beverages were held and served at proper temperatures. Findings include: Per review of Prepared food temperature logs for the past year (2/2017 - 2/2018), there is no indication that milk, juice, coffee or teas are being monitored for proper temperatures. This was confirmed by the Dietary Manager on 2/13/18 at 8:48 AM.	F 812		

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F 838 SS=C	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures	F 838	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F 838 For all residents of the Facility a Facility Assessment will be completed. The Interdisciplinary Team will complete the Facility Assessment. The IDT will review the Facility assessment as required regularly and as needed at QAPI. The Administrator will be responsible for this plan of correction. F838 POC accepted 3/19/18 LLoverro/pmc	3/5/18

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F 838	Continued From page 10 and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to conduct and document a facility-wide assessment which includes all personnel, managers, staff and volunteers, as well as their education and/or training and any competencies related to resident care. Findings include: 1. During the entrance conference on 02/12/18 09:27 AM and later confirmed during the QAPI interview on 02/14/18 at 10:58 AM, the Administrator and the Director of Nursing Services (DNS) reported that they are working to complete the Facility Assessment, but it is not yet complete.	F 838		

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F 838	Continued From page 11 2. During interview on 2/13/18 at approximately 10:30 AM, the Director of Nursing Services (DNS), and later the unit manager at 1:00 PM, confirmed that planning has begun for staff competencies, trainings and scope of practice. However, during interview on 2/13/18 at 1:54 PM, the Administrator confirmed that the personnel and competency section of the facility assessment has not yet been completed or fully documented.	F 838		